



STATE OF TENNESSEE
COUNCIL ON CHILDREN'S MENTAL HEALTH

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Council on Children's Mental Health
June 25, 2009
10:00 a.m. – 3:00 p.m.
United Way of Middle Tennessee
MEETING SUMMARY

Participant List:

Susan Adams	Karen Franklin	Elvira Newcomb
Carla Babb	Deborah Gatlin	Linda O'Neal
Mark Baldwin	Nneka Gordon	John Page
Sumita Banerjee	Kathy Gracey	Cindy Perry
Cheryl Beard	Betty Adams Green	Steve Petty
Kathy Benedetto	Veronica Gunn	Norman Redwing
Bonnie Beneke	David Haines	Mary Rolando
Shawn Brooks	Vickie Harden	Rhonda Rose
Pam Brown	Robbie Hutchens	Traci Sampson
Aaron Campbell	Beth Hutto	Steve Sparks
Angelia Cannon	E. Ann Ingram	Debrah Stafford
Jason Chapman	Jeanne James	Tom Starling
Nicole Cobb	Thomas Jones	Susan Steckel
Michelle Covington	Sheila Keith	Millie Sweeney
Mike Cull	Dustin Keller	Linda Tift
Tracey Davis	Richard Kennedy	Pat Wade
Katrina Donaldson	Anthony L. King	Ellyn Wilbur
Bob Duncan	Paul Lefkowitz	Marie Williams
Emel Eff	Kim Crane Mallory	James Witty
Richard Epstein	Robert L. Matthews	Christina Yerian
Jeff Feix	Michael Myszka	

Welcome, Introductions and Meeting Summary Acceptance (Commissioner Virginia Trotter Betts and Linda O'Neal)

- Commissioner Betts introduced her daughter, Jessica Betts, who works for United Way of Middle Tennessee, host of today's Council on Children's Mental Health meeting.
- Linda O'Neal welcomed Dustin Keller as the new CCMH Director and thanked Susan Steckel for her work on the meeting summaries over the last year.

- O'Neal entertained a motion to accept the Meeting Summary for the April 23-24, 2009 CCMH meeting. Veronica Gunn moved, Millie Sweeney seconded. Motion passed unanimously.

Child and Adolescent Needs and Strengths (CANS): Overview, Properties, Principles, How Common Assessment Benefits a System of Care (John Lyons, University of Ottawa)

- Michael Cull introduced John Lyons of the University of Ottawa, Children's Hospital of Eastern Ontario and father of the CANS.
- *Refer to John Lyons PowerPoint Presentation "Total Clinical Outcomes Management in the service of children with behavioral and emotional needs: an update" provided to CCMH members via June 30, 2009 email from Linda O'Neal.*

Presentation Notes:

- Lyons presented an overview of the CANS and its benefits. He cautioned if used improperly it creates more work rather than being a planning tool and facilitating conversation. Documentation is paperwork. If it stays as paperwork, it is not worth the time. We know the CANS can be a tool used in a variety of different implementation areas.
- Form → Tool → Framework for common assessment strategy
- How the CANS is used is dependent on who uses it. The form is free to use.
- We have a lot of good people who are committed to our children, but it is not true we work in a system that works in the best interest of the children. This is because the child serving system is complex. I would argue it is the single most complex of any system out there. Each adult working within the system operates from a different perspective and with different goals than other adults who work in the same system, for example probation officer, teacher, case manager, mental health worker, etc. This causes tension across agencies, across responsibilities.
- The very nature of our work is conflict resolution, dispute resolution, and managing competing pressures. Two ways to resolve a dispute:
 1. If you are going to resolve a dispute, you need to have a shared vision. Do we have a shared vision of the child serving system? I think you do here in Tennessee. Can you have a shared vision and a hidden agenda? YES!!! That's part of what makes it difficult.
 2. You have to be able to communicate about the shared vision. If you cannot communicate the shared vision, disputes cannot be resolved. That's what a System of Care is and why it is centered around child and family teams. People who work directly with children don't have an issue with shared vision, supervisors are more concerned with supervisees, program folks are focused on policies and procedures, and system level folks focus on the allocation of funds.
- You cannot manage what you do not measure!!

- What do we routinely measure? - We measure the activities of professionals, so in essence that is all we manage. We would all agree that is not the best way to manage a system.
- Managing tension is the key to creating an effective system of care, including tension based on philosophy, strategy and tactics. Transformation is positive change.
- Informed consent changes the nature of the relationship. Examples of outcomes from informed consent include:
 1. People are more honest with researchers than clinicians.
 2. Substance abusing girls “self-esteem” plummets with treatment.
 3. Method matters with consumer satisfaction.
 4. Consumers and providers use assessment for advocacy for services rather than accuracy. Clinical assessment is used to diagnose the least stigmatizing diagnosis with the best likelihood for reimbursement. The data is fraudulent because it is based on “diagnoses for dollars”. Emerging evidence shows what we do is actually effective, but it is only effective for people who need it, it is actually harmful for people who don’t need it. In truth, accuracy is advocacy.
 5. Measures developed for research do not translate well into service delivery applications. The priorities of research are fundamentally different from the priorities of service delivery. The only reason to do an assessment is to determine what to do next. You only want information that is relevant to the work.
 6. The CANS is developed from communication theory, not psychometric theory. This does not replace specialization of different groups, it just informs the communication of the shared vision. Constitutive communication is creating a shared meaning, which is exactly the same concept as System of Care. This is the context in which the CANS is used best.
 7. Professionals have broad expertise; people have deep expertise. This creates a lot of tension. We have to find a way to blend this expertise because they are both important. The way you do it is through finding a shared meaning, a consensus process to reinforce the notion that this is a shared process.

The Strategy: CANS

Six Key Characteristics of a Communimetric Tool

1. Items are included because they might impact service planning;
 2. Level of items translates immediately into action levels;
 3. It is about the child, not about the service;
 4. Culture and development are considered;
 5. It is agnostic as to etiology – it is about the ‘what’ not about the ‘why;’
 6. The 30 day window is to remind us to keep assessments relevant and ‘fresh,’ but is not a concrete rule.
- CANS is used to determine strengths and needs. On a scale of 0-3, 2s and 3s are priorities because they interfere with functioning. For example, 0 strength is kinship care, 1 is a resiliency skill but ‘watchful waiting’, 2s and 3s need addressing. The CANS informs the planning process.

- The shared vision is to represent children and families, not children and services. The goal is to determine the need, not the service.
- Assessment done at a residential facility is irrelevant because it is a setting effect due to the type of setting. You need to determine the treatment effect vs. the setting effect. For example, a youth in a residential setting may be stable and not a runaway risk; however, when they return home, they could easily be at risk again.
- Consider culture and development before the common assessment is developed. Sometimes we have to learn how to treat different people differently, sometimes we have to learn how to treat different people the same. This is culture sensitivity vs. racism.
- The CANS is a descriptive tool; it's about the what, not about the why. Stigma and shame are encompassed in the why, not the what. There are no Diagnostic Statistical Manual (DSM-IV) diagnoses that have a known pathogen, so if you jump to the why too soon, you have a good chance of being wrong.
- The 30 day window is an arbitrary number, but it is used to keep the assessment fresh. People get better or get worse and that needs to be communicated to children and families, but not, "you are a screw up and you can only get worse," which is what risk assessments tend to do as used in the juvenile justice system.
- CANS is a thinking tool. Parents complain assessments are too numerous and they don't know what they mean. CANS addresses both of these, as a common assessment reduces the total number of assessments needed across systems and parents can easily understand what they mean.
- The power of a common language is to create respect across systems and an even playing field. You have to integrate from the child out, not from the top down.

Understanding our Marketplace
The Hierarchy of Offerings:

1. Commodities – raw materials;
 2. Products – gasoline;
 3. Services – hire someone to apply a product for you - butcher, grocer, drycleaners;
 4. Experiences – Games, buying a memory or an experience - Disney World;
 5. Transformations – Hired to help people make a fundamental change in their life.
- The goal of the CANS is to measure the transformation offering so we can manage the transformational offering that is the goal of the child serving system.
 - Discussion of TCOM Grid of Tactics (slide 15).

- Information, intuition, theory: most people make most decisions about the system based on intuition, which is mostly based on vivid experience. Information is the best way to communicate the shared vision. What do I do? Is it working? Can I do it better? What people are paid to do is often not what they know they should be doing or what is in the best interest of children.

General Discussion with John Lyons

Traci Sampson: Have you actually seen policy change in other states?

Lyons: New Jersey has a system of care initiative and uses the CANS to reduce residential treatment to only when needed. You can't actually have an effective/successful Wraparound program. How do you actually transition children out of Wraparound who still have needs? The back door is very difficult. They have transitioned their business model to a case manager that provides case management as well as Wraparound when needed, so there is not pressure to complete a "program" and the focus is on the need.

Commissioner Betts: Where is the data or the science about the right algorithm or the validity of the algorithms?

Lyons: *Refer to the following slides:*

1. Figure 5.2. Survival Function for Patterns 1-3 (slide 19).
2. Figure 3. Comparison of Life Domain Functioning between CANS/CAYIT (slide 20).
3. Figure 2. Trauma Symptoms comparison between CANS/CAYIT (slide 21).
4. Figure 4. Comparison of Emotional/Behavioral needs between CANS/CAYIT (slide 22).

Commissioner: Can you refer to services that are not there?

Lyons: *Refer to Map of Chicago (slide 31).* Creation of human service ghettos because of "not-in-my-back-yard-ism."

Cindy Perry: This group is here to work on the child serving system. Have you worked with states that have used the CANS for their system?

Lyons: Yes. The problem is not lack of child-psychiatrists; it is a lack of child-psychiatrists who take Medicaid. You can use the CANS to evaluate your system, not just a program. If you are managing a system, you want to gather information that will inform your decisions so you can manage what you measure. A year is a reasonable start-up time. New Jersey is an example of a state that uses the CANS regardless of portal of entry.

Vickie Harden: How do you compensate for the CANS assessment having a different bent because a juvenile justice officer filled it out and then sent it to a mental health worker?

Lyons: The CANS does not eliminate this issue, but it makes it transparent so you can start to deal with it.

Tracey Davis: How does it address the reimbursement issue? Insurance companies are driven by diagnoses. How do we change that? We don't treat kids; we treat what will be reimbursed.

Lyons: That is a journey. I predict that Managed Care companies will go away if they are not careful because they are not incentivized for treatment outcomes.

Traci Sampson: How did New Jersey make the transition?

Lyons: I can't really answer that question because I wasn't in the rooms where the decisions were made. I try to make this about the children, not about me. He provided an example where the CANS was referred to as the "Lyons tool." Value Options did not get the New Jersey contract because they could not provide outcomes because their system was set up based on claims, not episodes of care. They struggled for six years to be able to provide outcomes from their claims based system.

Presentation of Department of Children's Services CANS Data (Michael Cull and Richard Epstein, Vanderbilt University)

For this section, refer to the following documents provided to CCMH members via June 30, 2009 email from Linda O'Neal:

- 1) CANS Implementation: Department of Children's Services PowerPoint presentation;
 - 2) CANS Comprehensive Multisystem Assessment Manual – Tennessee Version;
 - 3) John Lyons PowerPoint Presentation: Total Clinical Outcomes Management in the service of children with behavioral and emotional needs: an update.
- CANS is focused on the "what" not the "why." The items in the tool are discussed directly with parents. Every item has its own set of anchors for individual ratings and trained raters will be able to refer to the manual at all times. The electronic version contains a hover function so the anchors are more easily accessible.
 - CANS items are reliable at the item level, so the CANS can be tailored around specific needs, populations.
 - Data from individual items can be analyzed at the individual level, but the data can be grouped by domain (i.e. risk behaviors, emotional social, etc.) which are then thought of as complexity scores. The data can be represented by the number of items with a 2 or 3 score within each domain. There is no need to add up the scores.
 - How do you get from CANS score to intervention planning? A score of 3 is an immediate need that needs to be addressed and a 2 is a high priority. The planning is more specific to domain needs, incorporating the centerpiece strengths, i.e. suicide risk, etc.
 - Treatment is addressing the theory of why there are treatment needs: 1) Evidenced-based practice (EBP) approach to treatment (cognitive-behavioral therapy (CBT), etc.); 2) Patterns of actual needs, i.e. self-injurious behavior, development needs. For example, you can implement a behavior management plan vs. a trauma-informed strategy to address self-injurious behavior; and 3) Have the youth and family create a theory of why and then go from there.

- What about trainer issues and inter-rater reliability? The rule about the CANS is that no one can use the CANS except for people who are trained to use the CANS, it is not limited to jurisdiction or field. Parents can be trained to use it as well. DCS has successfully trained all of their case workers to use the CANS. DCS has set up an internal reliability structure to add oversight and controls for the data collected.
- Inter-rater reliability: Having different perspectives is good and is not the issue. The fact that there are different perspectives from various raters IS the point.
- Digging deeper: Trauma and alcohol and drug issues trigger a secondary module that asks more specific questions to get a deeper sense of the issues.

Digression from agenda to discuss comment around incorporating the CANS into the Division of Alcohol and Drug assessment needs.

- Lyons: The philosophy is to have service availability information available at the time of assessment via an interactive web-based system.
- The CANS can be used as a treatment planning tool and as a decision support tool. Algorithms can be developed to support these needs. DCS uses an algorithm to support treatment recommendations such as residential treatment, etc., which are then discussed with the family and they have the choice whether or not to follow the recommendation. *Refer to DCS PowerPoint (slide 4): CANS Algorithm Services Intensity Recommendation as of April 2009.*
- The most important thing that creates consistent reliability is USE. Getting people to actually use the tool is one of the most challenging aspects of this work.
- Is there as much training around what to do with the scores as there is around the scoring itself? You will see a transition to intensity of services from level of care post implementation. We do know that you cannot train people on what to do with the scores at the same time as you are training them on how to score the tool. It is a step by step process.
- The CANS can be useful at any level.
- Outcomes measured at the item level can inform programs, domain level, algorithm level. *Refer to Lyons PowerPoint slides: Key Decision Support CSPI Indicators ... (slide 33) and Change in Total CSPI Score by Intervention and Hospitalization Risk Level (FY06) (slide 34).* Measuring 90 day crisis period hospitalizations for low risk children actually makes outcomes worse for that population (still at 20 percent of admissions to hospitals). The low functioning kids are the ones that get admitted into hospital. Who gatekeeps the hospitalizations? That's why mobile crisis is so important.

- What information is used to rate the CANS? Common question, the design is that one will make a determination based on all the available information. Some raters will have more information than others. The CANS provides a structure from which to inform a person's decision. DCS is more concerned with quality versus forcing a rater to input information they are not sure about, multiple raters fill out the CANS until there is sufficient information to fill it out properly. They cut it off at the Child and Family Team (CFT) and redo it every 6 months (3 months for high need children) or at transition or discharge. DCS is making strides with providers in terms of the use of the CANS at certain times (i.e. discharge). Multiple raters force the conversation between agencies and bring people to the table to discuss specific items.
- The CANS information can be easily provided to the schools. There is a school specific version of the CANS based on the social emotional learning model. Department of Education (DOE) is in talks with John Lyons and Vanderbilt about implementing the CANS.
- Hospitals are beginning to use the CANS as a discharge communication tool (i.e. discharge report).
- Caregiver needs and strengths are addressed in the CANS in every version for the purpose of addressing caregiver involvement and care planning around the caregiver in addition to rating the child. This comes into play at the level of service planning where you need to determine a theory of why.
- Algorithms are patterns of actionable needs: high risk behavioral, functional disability, school attendance issues.
- Discussion of DCS CANS data: *Refer to DCS PowerPoint Slides 7-13.*
 - o Data show children are disproportionately minority and male.
 - o Three most prevalent risk behaviors per age group (items most often rated with a score of 2 or 3).
 - o Older children are rated as having different needs than younger children. 13-16 year old children are more likely to exhibit high risk behavior.
 - o Regarding Sexually Problematic Behaviors (GOCCC analysis) data show a striking trend in difficulties with adjustment to trauma. There is a strong association with difficulties with adjustment to trauma and sexually problematic behavior. Sexually aggressive children are a separate issue because there are some sexually aggressive children who are not trauma survivors.

Discussion Regarding Common Assessment Tool (CCMH Members)

O'Neal: Would the group like a four hour CANS training? Yes. We would also like to see a case study, or the training in application. Explore an alternative to a CCMH meeting training.

Question: How are we going to make a decision about which common tool to use?

Many CCMH members commented strongly on the need for more information about the CANS and the various/potential uses for the CANS before the group makes the difficult decision to use the CANS across agencies and statewide. It was noted that implementing a common assessment tool will be very challenging for all involved and that the subject should be thoroughly studied and considered before a decision is made.

O'Neal: We will explore how we will move forward on this issue, whether we have a full four hour CANS training, make that training available and/or bring in DCS employees to provide the group with case studies so the training in action piece can be explained.

Cindy Perry: Which states would you recommend we look at that are comparable to Tennessee?

Lyons: Indiana, Wisconsin, Massachusetts, New York, Virginia (System of Care model). Juvenile Justice applications vary; none are statewide so far. A number of System of Care sites are using the CANS as part of the local evaluation. More information can be found at: www.praedfoundation.org.

JCCO Workgroup Report and JCCO Legislation (Shay Jones, Jeff Feix, David Haines and Aaron Campbell)

- Refer to "2009 Juvenile Court Evaluation Legislative Package" handout from meeting and provided to CCMH members via June 30, 2009 email from Linda O'Neal.
- Thanks to all of the members of the JCCO Workgroup that helped us pass this bill and work on this issue.
- Judge Green: This is working really well because we have a detention center, a place where the child can remain while the evaluation is being done. It is very problematic for judges that do not have access to a detention center, which is 70-80 percent of the counties.
- Haines: I think we could use this new fund to help with this issue and give counties increased access to funds to pay for out-of-county placements.
- O'Neal: The JCCO workgroup has known for a long time that this issue has really been more about placement than about evaluations.

Legislative/Budget Update (Commissioner Betts, Linda O'Neal)

- Changes in suitable accommodations language, important to note that language referred to adults not children.
- Governor Bredesen has signed budget today. We are going to assume that there were no line item vetoes, so \$5 million non-recurring dollars were restored to community-based grants (84 percent restoration of funding to community grants that would have ended June 30, 2009.)
- We are still waiting on instructions from the Department of Finance and Administration (F&A).

- Post custody issue: Cindy Perry will be coordinating a Transitioning Youth Advisory Council. This council applies to more than just DCS children. It also applies to those in the mental health and education systems. The efforts are to generate a more seamless and coordinated system of services for transition age youth. The legislation also requires state agencies to identify transition age youth within their systems, to “cast a wider net,” for referral to DCS and other resource centers with available services and information.

Discussion Plans for Future Meetings (Facilitated by Linda O’Neal)

- August 20th is next meeting (Ellington Agricultural Center).
- More information about how the CANS is used.
- Evidenced-based services committee update.
- Other workgroup activity – redefine, recharge. Discuss where we are with all of them.
- Timeline for making decisions, as next report is due this time next year.
- MIS workgroup will convene a CANS related conference call to augment case related discussion around the tool.

Meeting Summary prepared by Susan Steckel, TDMHDD.